TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
DOCTORS HOSPITAL AT RENAISSANCE

**Respondent Name**
TEXAS COTTON GINNERS' TRUST

**MFDR Tracking Number**
M4-17-2077-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
March 7, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "After reviewing the account we have concluded that reimbursement received was inaccurate."

**Amount in Dispute:** $634.64

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Wellcomp maintains the payment recommendation of $2656.84 is correct."

**Response Submitted by:** Texas Cotton Ginners' Trust

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 18, 2016 to March 21, 2016 | Outpatient Hospital Services | $634.64 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PYMT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - P14 – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

**Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

**Findings**

1. This dispute regards outpatient hospital facility services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule.

   Based on the submitted medical bill, per Rule §134.403(f)(1), the MAR is calculated by multiplying the sum of the Medicare facility specific amount and any applicable outlier payment by 200 percent.

2. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and services without procedure codes is packaged into the payment for the APC. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov. Reimbursement for the disputed services is calculated as follows:
   - Procedure codes A6222, 88341, 64778, Q4124, J2370, J2405, J2250, J2765, J0690 and J3010 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
   - Procedure codes 36415 (dates of service March 18 and March 21, 2016), 84132, 84295, 85027, 85018 and 85014 have status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
   - Procedure code 88342 has status indicator Q2, denoting T-packaged codes; reimbursement for these services is packaged with payment for procedure codes 64776 and 64999 billed on the same claim. These services are separately payable only if no other status T procedures are billed.
   - Procedure codes 88304 and 93005 have status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with payment for any procedures with status indicators S, T or V. These services are separately payable only if no other such procedures are billed.
   - Procedure code 64776 has status indicator T, denoting significant outpatient procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 100%. This is assigned APC 5431. The OPPS Addendum A rate is $1,392.56. This is multiplied by 60% for an unadjusted labor-related amount of $835.54, which is multiplied by the facility wage index of 0.7989 for an adjusted labor amount of $667.51. The non-labor related portion is 40% of the APC rate, or $557.02. The sum of the labor and non-labor portions is $1,224.53. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement of $1,224.53 is multiplied by 200% for a MAR of $2,449.06.

- Procedure code 64999 has status indicator T, denoting significant outpatient procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 50%. This is assigned APC 5441. The OPPS Addendum A rate is $223.76. This is multiplied by 60% for an unadjusted labor-related amount of $134.26, which is multiplied by the facility wage index of 0.7989 for an adjusted labor amount of $107.26. The non-labor related portion is 40% of the APC rate, or $89.50. The sum of the labor and non-labor portions is $196.76. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific reimbursement, including multiple-procedure reduction, of $98.38 is multiplied by 200% for a MAR of $196.76.
- Procedure code A9270 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.

3. The total allowable reimbursement for the disputed services is $2,645.82. The insurance carrier has paid $2,645.83, leaving an amount due to the requestor of $0.00. No additional reimbursement is recommended.

**Conclusion**

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

| | Grayson Richardson | March 28, 2017 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.